BlueCross BlueShield of North Dakota
NORIDIAN®
Mutual Insurance Company*

Health Benefit Plan Affiliation and Out-of-Area Waiver Form

(Please type or print in black ink)

Section 1 - Affiliation:

Please indicate the Network name and Network number you have chosen for you and your eligible dependents.

Network Name _____ Network Number _____

Section 2 - Out-of-Area Waiver:

Your or your living, covered spouse's Eligible Dependent children are eligible for this waiver if:

- They are residing at a facility for children with disabilities or other special needs (Anne Carlson School, etc.);
- They reside outside the Network Service Area and you or your living, covered spouse are required by court order to provide health coverage for them; or
- They are full-time students residing outside the Network Service Area who are financially dependent on you or your living, covered spouse.

I certify my Eligible Dependents listed below, meet at least one of the above requirements. I understand all Covered Services received by these Eligible Dependents will be reimbursed at the In-Network benefit level.

First Name:	Birthdate (mm-dd-yy)	Reside at a special needs facility	Covered by court order and residing out of area	Financially dependent full-time student residing out of area
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐
_____	_ _ _____	☐	☐	☐

I understand my Eligible Dependents and I must receive care within the Network I have selected, with the exception of Eligible Dependents listed in **Section 2 - Out-of-Area Waiver**. Use of providers outside my Network will result in a reduction of benefits, unless an authorized referral has been obtained or the Out-of-Area Waiver is in effect.

I authorize any Health Care Provider that has advised, treated, attended or provided care or service to me or my minor children, or is in possession of any medical information and records relating thereto, including medical information and records of DRUG AND ALCOHOL TREATMENT, MENTAL HEALTH TREATMENT AND COUNSELING AND HIV/AIDS TESTING, to furnish such medical information and records as requested to Noridian Mutual Insurance Company, d/b/a Blue Cross Blue Shield of North Dakota ("Noridian"). I further authorize Noridian to release such medical information and records to my Network Organization if I or my minor children are advised, treated, attended or provided care or service outside my Network Organization. I understand that this medical information and records will be used by my Network Organization for the management of our care.

Requested Effective Date: _____

Employer Name: _____

Employee Name: Last _____ First _____ M.I. _____

Employee Social Security #: _____

Employee Signature: _____ Date: _____

Spouse Signature (if to be insured): _____ Date: _____

White – Office Copy Canary – Representative Copy Pink – Customer Copy